Additional Bleed Disorder In-Home Nursing Visits

Member Information (required)	**Provider Information** (required)	
Member Name:	Provider Name:	
ID#:	NPI#:	Contact Person
Date of Birth:	Office Phone:	Office Fax:
Nursing Visit Information (required)		
Additional 15min units requested:	Total additional time requested:	

All information to be legible, complete and correct or form will be returned.
FAX DOCUMENTATION INCLUDING PROGRESS NOTES or
UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval (at least one of the following must be met):

- Has the patient experienced one or more bleeding episode(s)? ☐Yes ☐No
  - Episode 1: Medication used: _____
    Dose/Protocol: _____
  - Episode 2: Medication used: _____
    Dose/Protocol: _____
- Has the patient required delivery of additional factor/product/supplies? ☐Yes ☐No
  - Item(s) required: _____
- Has the patient/caregiver required additional education/training? ☐Yes ☐No
  - Education/training given: _____
- Was the patient/caregiver unable to administer factor/product without a Utah Medicaid-contracted health care professional? ☐Yes ☐No
- Did the patient visit the ER or Hospital that warrants extra visits? ☐Yes ☐No

Note: Per the Utah State Plan, hemophilia-related in-home nursing visits are provided by a single contracted entity. Reimbursement is based upon 15 minute units and capped at 8 units per month. Additional in-home visits may be authorized by the department on a case-by-case basis.

Authorization: One (1) month